DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
BUREAU OF HEALTH SYSTEMS

ADMINISTRATIVE RULES FOR
SUBSTANCE ABUSE SERVICE PROGRAMS

PART 7: OUTPATIENT PROGRAMS

PART 7. OUTPATIENT PROGRAMS

R 325.14701 Program staffing; admissions; criteria; forms; policies and procedures; information; eligibility.

701(1) The equivalent of 1 or more full-time counselors shall be available for approximately 40 clients.

701(2) Clearly stated written criteria for determining the eligibility of individuals for admission shall be developed.

701(3) Information gathered in the course of the intake and assessment process shall be recorded on internally standardized forms. The completed forms shall become part of the applicant's case record.

701(4) A program shall develop written policies and procedures to govern the intake process which shall set forth both of the following:

(a) The procedures to be followed when accepting referrals from outside agencies or organizations.
(b) The procedures to be followed, including those for referrals, when an applicant is found ineligible for admission.

701(5) All of the following information shall be collected and recorded for all applicants before, or at the time of, admission:

(a) Name, address, and telephone number, when applicable.
(b) Date of birth and sex.
(c) Family and social history.
(d) Educational history.
(e) Occupation.
(f) Legal and court-related history.
(g) Present substance abuse problem.
(h) Date the information was gathered.
(i) Signature of the staff member gathering the information.
(j) Name of referring agency, when appropriate.
(k) Address, telephone number, and name of nearest relative to contact in case of emergency.
(l) History of current and past substance abuse or other counseling services received. The agency, type of service, and the date the service was received shall be indicated.
(m) Name, address, and telephone number of the most recent family or private physician.
(n) A substance abuse history, including information about prescribed drugs and alcohol which indicates, at a minimum, all of the following information:
    (i) Substances used in the past, including prescribed drugs.
    (ii) Substances used recently, especially those used within the last 48 hours.
    (iii) Substances of preference.
    (iv) Frequency with which each substance is used.
    (v) Previous occurrences of overdose, withdrawal, or adverse drug or alcohol reactions.
    (vi) History of previous substance abuse treatment received.
    (vii) Year of first use of each substance.

701(6) During the admission process, every effort shall be made to assure that an applicant understands all of the following:

(a) General nature and objectives of the program.
(b) Rules that govern client conduct and infractions that can lead to disciplinary action or discharge from the program.
(c) Hours during which services are available.
(d) Costs to be borne by the client, if any.

R 325.14702 Withholding information.

702(1) An applicant shall retain the right to withhold any information that is not demonstrably necessary to the treatment process or to essential program operations.

702(2) If a program finds it necessary to require certain information in addition to that described in R 325.14701 (5) and (6) as a condition of admission, there shall be a written policy delineating such information.

702(3) If an applicant refuses to divulge such additional and necessary information, the refusal shall be noted in the client case record.

R 325.14703 Admission ineligibility.

703 If an applicant is found to be ineligible for admission, the reason shall be recorded in the client case record and, if appropriate, a referral to an appropriate agency or organization shall be attempted.

R 325.14704 Medical examination and information.

704(1) A program that does not require a medical examination for admission shall make a determination of the necessity or advisability of a medical examination for each client.

704(2) At the time of admission, inquiry shall be made to determine if a client has any physical disabilities, limitations, or ailments. Disabilities, limitations, and ailments shall be recorded in the client file.

704(3) Based upon medical information provided by the client, referrals shall be made to a licensed physician as deemed appropriate by the counselor. Action taken shall be recorded in the client file.

R 325.14705 Treatment plans.

705(1) There shall be an assessment of each client's social and psychological needs. The areas of concern shall include a determination of the following:

(a) Current emotional state.
(b) Cultural background.
(c) Vocational history.
(d) Family relationships.
(e) Educational background.
(f) Socioeconomic status.
(g) Any legal problems that may affect the treatment plan.

705(2) Based upon the assessments made of a client's needs, a written treatment plan shall be developed and recorded in the client's case record. A treatment plan shall be developed as soon after the client's admission as feasible, but before the client is engaged in extensive therapeutic activities. The treatment plan shall conform to all of the following:

(a) Be individualized based upon the assessment of the client's needs and, if applicable, the medical evaluation.
(b) Specify those services planned for meeting the client's needs.
(c) Include referrals for services which are not provided by the outpatient care component.

(d) Contain clear and concise statements of the objectives the client will be attempting to achieve, together with a realistic time schedule for their achievement.

(e) Define the services to be provided to the client, the therapeutic activities in which the client is expected to participate, and the sequence in which services will be provided.

705(3) Review of, and changes in, the treatment plan shall be recorded in the client's case record. The date of the review or change, together with the names of the individuals involved in the review, shall also be recorded. A treatment plan shall be reviewed at least once every 90 days by the program director or his or her designee.

R 325.14706 Client counseling.

706 Two or more hours of formalized individual, group, or family counseling shall be available to each client each week. The hours of counseling actually provided should vary according to the needs of the client.

R 325.14707 Progress notes.

707(1) A client's progress and current status in meeting the objectives established in the treatment plan, together with a statement of the efforts by staff members to help the client achieve these stated objectives, shall be recorded in the client's case record for every formal client counseling session. A progress note shall be dated and signed by the individual who makes the entry.

707(2) If a client is receiving services at an outside resource, the program shall attempt to secure a written case summary, case evaluation, and other client records from that resource. These records shall be added to the client's case record.

707(3) The ongoing assessment of the client's progress in respect to achieving treatment plan objectives shall be used to update the treatment plan.

R 325.14708 Client discharges.

708(1) Within 2 weeks after discharge, the counselor shall enter in the client's case record a discharge summary describing the rationale for discharge, the client's treatment and rehabilitation status or condition at discharge, and the instructions given to the client about aftercare and follow-up.

708(2) Unless a client leaves voluntarily before his or her course of treatment is completed, a client shall not be discharged from a program while physically dependent upon a drug prescribed for him or her by the program physician, unless the client is given an opportunity to withdraw from the drug under medical supervision and at a rate determined by the program physician or the client is referred to an outside resource which is willing to continue administering the drug.

708(3) The offer to provide withdrawal or referral to another resource shall be made both orally and in writing. If the client refuses such an offer, the program shall attempt to secure a signed statement from the client which verifies that the offer was made to, and was rejected by, the client. Failing that, a progress note shall be recorded documenting the attempt.

R 325.14709 Aftercare plan.

709(1) If a program provides aftercare services, a written aftercare plan shall be developed in partnership with the client before the completion of treatment. The aftercare plan shall state the objectives for the client for a reasonable period following discharge. The plan shall also contain the description of the services the program will provide during the aftercare period, the procedure the client is to follow in reestablishing contact with the program, especially in times of crisis, and the frequency with which the program will attempt to contact the client for purposes of follow-up.

709(2) The date, method, and results of attempts at contact shall be entered in the client's case record and shall be signed by the individual who makes the entry. If follow-up information cannot be obtained, the reason for failing to obtain the information shall be entered in the client's case record.

709(3) Regardless of the method of contact utilized, the program shall protect the confidentiality of the client. Mailing envelopes that are identifiable as originating from the program shall not be mailed to a client. A post office box number may be used to determine if mail was undeliverable and to facilitate follow-up.

R 325.14710 Confidentiality of follow-up.

710 If the program attempts to determine the status of clients who have been discharged, and if this attempt is made for purposes other than determining the disposition of a referral or for research purposes, such follow-up shall be limited to methods which either assure client confidentiality or require formal written consent of the client.

R 325.14711 Maintenance of client records.

711(1) There shall be a case record for each client. All of the following items shall be filed in the case record, if applicable:

(a) Results of all examinations, tests, and other assessment information.
(b) Reports from referring sources.
(c) Treatment plans.
(d) Records of referrals to outside resources.
(e) Reports from outside resources, which shall include the name of the resource and the date of the report. These reports shall be signed by

the person who makes the report or by the program staff member who receives the report.

(f) Case conference and consultation notes, including the date of the conference or consultation, recommendations made, and actions taken.

(g) Correspondence related to the client, including all letters and dated notations of telephone conversations relevant to the client's treatment.

(h) Treatment consent forms.

(i) Information release forms.

(j) Progress notes. Entries shall be filed in chronological order and shall include the date any relevant observations were made, the date the entry was made, and the signature and staff title of the person who makes the entry.

(k) Records of services provided. Summaries of services provided shall be sufficiently detailed so that a person who is not familiar with the program can identify the types of services the client has received. General terms such as "counseling" or "activities" shall be avoided in describing services.

(l) Aftercare plans.

(m) Discharge summary.

(n) Follow-up information.

711(2) A program shall provide sufficient facilities for the storage, processing, and security of client case records. These facilities shall include suitably locked and secured rooms and files.

711(3) Appropriate records shall be readily accessible to those staff members who provide services directly to the client.

711(4) A client case record shall be maintained for not less than 3 years after services are discontinued.

711(5) If a program stores client data on magnetic tape, computer files, or other types of automated information systems, security measures shall be developed to prevent inadvertent or unauthorized access to data files.

R 325.14712 Support and rehabilitative services.

712(1) All of the following support and rehabilitative services shall be available to all clients either internally or through the referral process:

(a) Education.

(b) Vocational counseling and training.

(c) Job development and placement.

(d) Financial counseling.

(e) Legal counseling.

(f) Spiritual counseling.

(g) Nutritional education and counseling.

712(2) A program shall maintain a current listing of services available on-site and by referral. This listing shall be reviewed with each client as part of the program's orientation procedure.